



Annual Traction/Drum Elevator Safety Test

Mail this form to: Ohio Department of Commerce, Elevator Inspection Section,
6606 Tussing Road, Reynoldsburg, OH, 43068-9009
Original must be filed within 5 days of test.

www.com.state.oh.us/dic/dicelevators.htm

Location: _____	Address: _____
City: _____	Zip: _____ County: _____

INSTRUCTIONS: (Please complete both pages of the form)
 Safety Tests are required to be submitted as outlined in ASME A17.1 part 8, and Ohio Revised Code Chapter 4105. This test is required in addition to the field inspections by the State of Ohio. State Inspectors do not perform safety tests. File a completed safety test to the above address within 5 days following the completion of the test. Additional explanation of each test component can be found in the ASME A17.2 Inspector's Manual. Annual tests of Type A, B, and C safeties are to be conducted without weight on the platform and at slow speed. Counterweight safeties and buffers are to be tested without weight on the platform at slow speed. The governor is tripped by hand at slow speed. All test tags must be affixed to the appropriate devices, including the governor test tags, buffer tests tags and test tags on the car top crosshead on or near the governor rope. This form is to be completed for all acceptance testing for new or altered elevators. Acceptance testing is to be done in the presence of a State of Ohio inspector and in accordance with ASME A17.1 and ASME A17.2.

<p>Type of Unit: (Check one) *Hydraulic elevators and escalators have a separate test form. Please see our web site.</p> <p>Passenger <input type="checkbox"/> Freight <input type="checkbox"/></p> <p>Sidewalk Freight <input type="checkbox"/> Dumbwaiter <input type="checkbox"/></p> <p>Special Service <input type="checkbox"/> Stage Lift <input type="checkbox"/></p> <p>Chair Lift <input type="checkbox"/> LULA <input type="checkbox"/></p> <p>Vertical Wheel Chair Lift <input type="checkbox"/></p> <p>Other type not listed: _____</p>	<p>Type of Driving Machine: (Check one)</p> <p>Traction <input type="checkbox"/> Drum <input type="checkbox"/></p> <p>Rack & Pinion <input type="checkbox"/> Belt <input type="checkbox"/></p> <p>Chain & Sprocket <input type="checkbox"/> Screw <input type="checkbox"/></p> <p>Other type not listed: _____</p> <p>What type of Guide Rails? (Check one)</p> <p>Steel <input type="checkbox"/> Wood <input type="checkbox"/></p>	<p>Capacity (lbs): _____ Rated Speed (fpm): _____</p> <p>Total number of floors served _____ Total Travel (ft): _____</p> <p>What type of safety device does this unit have? (Check all that apply):</p> <p>Type A <input type="checkbox"/> Type B <input type="checkbox"/> Type C <input type="checkbox"/> Broken Rope <input type="checkbox"/></p> <p>What type of governor does this unit have? (Check one)</p> <p>Fly-ball <input type="checkbox"/> Centrifugal <input type="checkbox"/> Jawless <input type="checkbox"/></p> <p>Other (specify) _____</p>
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Complete all items in this section:	Yes	NO	N/A
Has the car governor and/or counterweight governor been inspected and operated? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the car or counterweight safeties been visually inspected? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Was the governor tripped by hand to set the safeties at slow speed for the test? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If the unit does not have a governor, were the safety and slack rope devices activated by obtaining the necessary slack rope? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Have the car and counterweight oil buffers been tested by fully compressing the buffer at slow speed, and did the oil buffer return within 90 seconds? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
For traction machines, did the unit loose traction during the testing of the safeties and the compression of the buffers, or did the control drive stall? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the ascending car-protection device been tested? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the unintended car movement device been tested? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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*Original must be filed with the elevator inspection section
within 5 working days of the completion of the test.*

Complete all items in this section for all safety devices:

	Yes	NO	N/A
Were the normal and terminal electrical stopping devices tested? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where provided, was the firefighter's service Phase I/II key switch inspected and tested? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where provided, was the standby emergency power inspected and tested? (Must have occurred within 12 months of safety test) Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where provided, was the broken rope, tape, or chain switches tested? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where provided, was the closing force of power operated hoistway door systems operated and tested? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where provided, was the emergency terminal stopping speed limiting devices tested? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Where provided, was the leveling zone, leveling speed and inner-landing zone tested as required? Comments: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DID THE UNIT PASS ALL TESTING REQUIREMENTS PRIOR TO BEING RETURNED TO SERVICE*	<input type="checkbox"/>	<input type="checkbox"/>	

***If "NO", a written statement as to why the unit failed must be filed with this office ASAP. THE UNIT MAY NOT RETURN TO SERVICE IF ANY SAFETY DEVICE FAILED unless the device was repaired and successfully re-tested.**

Company Conducting the Test: _____
 Address _____ City _____ Zip _____
 Person Conducting Test (Please Print): _____
 Signature (Must be signature of person conducting the test) _____ Date: _____
 Phone: _____ E-Mail address of Contact: _____